STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
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GOVERNOR

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DIRECTOR

MEDICAL DIRECTION & PRACTICE BOARD MEETING
MAY 17, 2006
MINUTES

In Attendance: S. Diaz, K. Kendall, D. Ettinger, P. Liebow, D. McKelway, E. Smith, J. Reynolds

Staff: J. Bradshaw, D. Kingdon, D. Kinney

MEMS Board Guest: T. Beals

Guests: A. Azarra, J. LaHood, D. White, G. Brockway, R. Petrie (Ops rep), J. LeBrun, D. Batsie (Ed. Rep), K. McGraw, R. Overlock, W. Waltz, D. Palladino, B. Zito, B. Chamberlain

I. Approval of March 2006 Minutes: Motion by Kendall, Second by McKelway, Unanimous approval.

II. Legislative, Budget, and EMStar Update by Bradshaw: Legislature not adjourned yet. The Budget is pending and no surprises yet found. EMStar is at the board and work on the High Level Recommendations from the Policy work group is underway. Will begin working on the role of the regional offices in June 2006 during a 2 day meeting. Liebow asked about term limits, and no action on this.

III. NAAK Training/Respiratory Plan: Presentation by John Bastin on the NAAK kits and respiratory protection. Handouts given for NAAK protocol, training, and recommendations. The NAAK kits are all ready purchased and in state having been bought by the RRCs previously. Also, the info of these being in state and waiting for protocols has been widely disseminated. Rollout would be regional train the trainers.
   a. Question of storage and Bastin recommends the NAAK's in and out of the ambulances with shift changes.
   b. Question of replacement of kits with expiration, and Bastin states that the RRCs will budget for replacement looking at HRSA grants or perhaps with help from the SNS.\
   c. Regarding Respiratory protection, long discussion over the used of escape hoods. Looking at the MSA escape hood, which does not require fit testing but will require appropriate sizing. There is a proposal to Maine CDC to fund this, as this was not currently budgeted for as were the NAAKs. Since NAAK exposure will most likely be a vapor exposure, using the NAAK alone if needed will not be appropriate protection. Actually, the algorithm for such an incident would be to remove yourself from the contaminant/exposure area, don your hood, and then administer NAAK for force protection. The hoods are $250/hood, and after many machinations, perhaps two

small, two medium and two large hoods per ambulance might be reasonable. Much discussion around this and noting that this would be a high-risk, low-incident occurrence so how much money should go towards it.

d. Vote on motion to accept NAAK protocols and training and accepting the concept of respiratory protection and that respiratory protection is a work in progress. Motion by Liebow, second by McKelway, with Liebow, McKelway, Ettinger, and Diaz for and Kendall and Smith against.

IV. Stroke Protocol: Dr. Ettinger presented a handout that his region would like to trial to improve timeliness of diagnosis of stroke. This may make treatment and decrease transport times. Cinicinnati, Los Angeles, and Miami have stroke scales. Handout circulated which shows the targeted exam and info transmitted. They would look at compliance of following protocol pre and post checklist. Their system had 200 patients in 2005 and this would be the baseline group, and will compare with next 200 patients as the intervention group. MDPB functions as an IRB in this type of procedure and our onus is to reasonably ascertain that the above change will not cause patient harm. The proposal differs from the current prehospital protocol.

a. Liebow noted that LOC is simple but may have some confounders
b. Azarra noted that some items in "Management Checklist" may not need boxes necessarily
c. Kendall noted two things: Change wording to "Last time appeared normal… or symptom onset if known" as one suggestion, and Hypertension box on form although we have no EMS protocol.
d. Will ask for 6 month feedback.
e. Motion to go forward with this is made by Kendall, second by Liebow, with Unanimous approval.

V. June Meeting Goals: We will set annual goals next month.

VI. Patient Sign Offs: Azarra brought in a handout to help us with the discussion of patient sign off who has capacity but EMS crew still with some concerns. The handout goes through the various parts of such a decision, but such a decision could be violating the patient's right to privacy. The simplest and most consistent message we can give is to contact OLMC if any concerns even in a patient with capacity, and let them help decide best course of action. Only with overt consent should EMS crews be contacting a patient's private physician if the patient has capacity for such a decision. We would benefit from a sign off lecture or conference, Bradshaw will look into this.

VII. OLMC: Held over with Busko and Sholl both away, this will be on the annual goals and we need to address this and have concrete deadlines.

VIII. Cardiac Advisory Committee/MEMS QI Update: 12 lead form to be discussed at MEMS QI today, good buy-in from 3 of the 4 therapuetic catheter centers, Smith states he will begin attending for York.

IX. PIFT Update: Batsie gave us an update. Beginning of Lesson Plan from Curriculum. Beta test sites/services to be determined in an equitable manner.

a. Question from Operations: Issues with the original content and can we grandfather those with previous PIFT training—this means a myriad of things and no way to track this, cannot grandfather those from previous PIFT programs.
b. Individual or Service-based program: Service-based due to many reasons such as medical direction, quality assurance,…
c. Tracking: this is an administrative or tech piece, operations will look at this.
d. Is this open to critical care technicians? No, this is a paramedic level training program.
e. Paramedic requirements of pre-entry training other than paramedic training? Originally had caveats of certain programs and one year experience with the feeling that this would be surrogate markers for experience or success without clear data that this is so. Additionally, we have been moving away from such surrogate markers and relying on our certificate of being a paramedic alone being appropriate for engaging in a paramedic program. Much discussion surrounding this without clear evidence of improving the student or the program. Motion by Smith with Second by McKelway to do away with the prerequisite language except the need for successful program completion to be PIFT paramedic. Smith, McKelway, Reynolds, Ettinger, Kendall and Diaz for and Liebow against. The document with this change has been recirculated.

X. IO Update: Batsie presented the EZ IO update with training plans (handout) and some follow-up suggestions. The Training should be approved by the regional medical director and Keep at the service level. Also, discussion to add the humerus site as Batsie has reviewed the data and looks equivalent to tibia—Diaz asked that the data be forwarded to him but in the interim, to move forward with addition of humeral site. Motion to adopt this program and the suggestions detailed above were with a first by Kendall, second by Ettinger, and unanimous approval.

XI. Kendall asked about regional medical directors having access to the electronic run reports for their regions. Bradshaw will follow-up on this.